		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028472

Facility Name: THREE SPRINGS LODGE NURSING HOME

Address: 161 THREE SPRINGS ROAD (Number) CHESTER (City) 62233 (Zip Code)

County: RANDOLPH

Telephone Number: (618)826-3210 **Fax #** (618)826-3821

IDPA ID Number: 371140355001

Date of Initial License for Current Owners: 08/01/72

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ROGER BAGLEY **Telephone Number:** (618)549-8331
JAMESTOWN MANAGEMENT

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) ROGER W. BAGLEY
(Title) CONTROLLER

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0028472 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	52	Skilled (SNF)	52	19,032	1
2		Skilled Pediatric (SNF/PED)			2
3	31	Intermediate (ICF)	31	11,346	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	83	TOTALS	83	30,378	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			280	280	8
9	SNF/PED					9
10	ICF	18,922	8,271		27,193	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,922	8,271	280	27,473	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.44%

D. How many bed-hold days during this year were paid by Public Aid?
52 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/01/72

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 280

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOM # 0028472 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	124,409	5,682	6,254	136,345		136,345		136,345			1
2	Food Purchase		88,970		88,970	(4,031)	84,939	(264)	84,675			2
3	Housekeeping	64,153	6,327		70,480		70,480		70,480			3
4	Laundry	45,616	5,682		51,298		51,298		51,298			4
5	Heat and Other Utilities			61,089	61,089		61,089		61,089			5
6	Maintenance	19,316	17,823	27,180	64,319		64,319	3,524	67,843			6
7	Other (specify):*											7
8	**TOTAL General Services**	253,494	124,484	94,523	472,501	(4,031)	468,470	3,260	471,730			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	780,219	25,363	950	806,532	(5,309)	801,223		801,223			10
10a	Therapy	34,300		6,801	41,101		41,101		41,101			10a
11	Activities	36,706	1,681	2,160	40,547		40,547		40,547			11
12	Social Services	19,470		2,160	21,630		21,630		21,630			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	870,695	27,044	12,071	909,810	(5,309)	904,501		904,501			16
	C. General Administration											
17	Administrative	75,065			75,065		75,065		75,065			17
18	Directors Fees											18
19	Professional Services			131,647	131,647		131,647		131,647			19
20	Dues, Fees, Subscriptions & Promotions			4,312	4,312		4,312	(1,706)	2,606			20
21	Clerical & General Office Expenses	21,680	5,832	6,123	33,635		33,635	(1,424)	32,211			21
22	Employee Benefits & Payroll Taxes			141,066	141,066	49,786	190,852	(2,334)	188,518			22
23	Inservice Training & Education			247	247		247		247			23
24	Travel and Seminar			4,132	4,132		4,132		4,132			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			48,334	48,334	(40,446)	7,888		7,888			26
27	Other (specify):*											27
28	**TOTAL General Administration**	96,745	5,832	335,861	438,438	9,340	447,778	(5,464)	442,314			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,220,934	157,360	442,455	1,820,749		1,820,749	(2,204)	1,818,545			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME #0028472 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			25,883	25,883		25,883	5,865	31,748			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							15,479	15,479			33
34	Rent-Facility & Grounds			252,000	252,000		252,000	(252,000)				34
35	Rent-Equipment & Vehicles			218	218		218		218			35
36	Other (specify):*											36
37	**TOTAL Ownership**			278,101	278,101		278,101	(230,656)	47,445			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		21,823	14,439	36,262		36,262		36,262			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			45,568	45,568		45,568		45,568			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		21,823	60,007	81,830		81,830		81,830			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,220,934	179,183	780,563	2,180,680		2,180,680	(232,860)	1,947,820			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0028472 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,241)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(264)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(105)	21		18
19	Entertainment	(245)	21		19
20	Contributions	(1,074)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,451)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(455)	20		28
29	Other-Attach Schedule	1,390			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (10,445)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(222,415)	SCHVII	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (222,415)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (232,860)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

THREE SPRINGS LODGE NURSING HOME

ID# 0028472

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	LINE 29 DETAIL	$		1
2	IRA EMPLOYER CONTRIBUTION	(2,334)	22	2
3	1 YR IDPH LICENSE (1YR ELIMINATED IN 1999)	200	20	3
4	DEFERRED PAINTING AMORITIZATION SCH XIX	3,524	6	4
5				5
6				6
7				7
8				8
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10				10
11				11
12				12
13				13
14				14
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87				87
88				88
89				89
90	**Total**	1,390		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0028472 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(264)	0	0	0	0	0	0	0	0	0	0	(264)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	3,524	0	0	0	0	0	0	0	0	0	0	3,524	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	3,260	0	0	0	0	0	0	0	0	0	0	3,260	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,706)	0	0	0	0	0	0	0	0	0	0	(1,706)	20
21	Clerical & General Office Expenses	(1,424)	0	0	0	0	0	0	0	0	0	0	(1,424)	21
22	Employee Benefits & Payroll Taxes	(2,334)	0	0	0	0	0	0	0	0	0	0	(2,334)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(5,464)	0	0	0	0	0	0	0	0	0	0	(5,464)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,204)	0	0	0	0	0	0	0	0	0	0	(2,204)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME **#** 0028472 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(8,241)	14,106	0	0	0	0	0	0	0	0	0	5,865	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	15,479	0	0	0	0	0	0	0	0	0	15,479	33
34	Rent-Facility & Grounds	0	(252,000)	0	0	0	0	0	0	0	0	0	(252,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(8,241)	(222,415)	0	0	0	0	0	0	0	0	0	(230,656)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(10,445)	(222,415)	0	0	0	0	0	0	0	0	0	(232,860)	45

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0028472 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
IRENE WELGE	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	DEPRECIATION	$	IRENE WELGE	100.00%	$ 14,106	$ 14,106	1
2	V	34	RENT	252,000	IRENE WELGE	100.00%		(252,000)	2
3	V	33	R E TAXES		IRENE WELGE	100.00%	15,479	15,479	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 252,000			$ 29,585	$ * (222,415)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number THREE SPRINGS LODGE NURSING HO! # 0028472 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	KENNETH ROWALD	ADMINISTRATOR	ADMINISTRATIV	0.00	0	40	100.00	SALARY	$ 75,065	L17/C1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 75,065		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0028472 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOM # 0028472 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	NONE						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME **#** 0028472 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	15,479	2
3. Under or (over) accrual (line 2 minus line 1).	$	15,479	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	15,479	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	11,715	8
	1996	12,195	9
	1997	15,139	10
	1998	15,311	11
	1999	15,479	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0028472 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,580 B. General Construction Type: Exterior MASONRY Frame STEEL & MASONRY Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME IS ON			$	1
2	OWNERS FARM LAND				2
3	TOTALS			$	3

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0028472 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	83		1972	1972	$ 433,938	$	40	$ 10,848	$ 10,848	$ 308,262	4
5			1972	1972	225,462		20			225,462	5
6			1972	1972	7,170		10			7,170	6
7			1982	1982	22,500		20	1,125	1,125	20,813	7
8			1972	1972	(24,888)					(24,888)	8
	Improvement Type**										
9	LANDSCAPE & SPRINKLER			1975	2,335		20			2,335	9
10	VARIOUS(PARKING LOT, SPRINKLER, NURSE CALLS)			1976	6,814		10			6,814	10
11	PARKING			1972	892		3			892	11
12	REMODELING/LAUNDRY REMODELING			1974	1,956		10			1,956	12
13	REMODELING			1975	413		10			413	13
14	OIL & CHIP DRIVE			1978	605		5			605	14
15	ELECTRICAL			1973	399		20			399	15
16	FREEZER/ BOILER			1981	10,608		10			10,608	16
17	SHOWER WALLS			1982	7,728		10			7,728	17
18	SHOWER WALLS			1983	9,279		10			9,279	18
19	PUMPS & EXHAUST			1984	3,032		10			3,032	19
20	FREEZER REPAIRS			1986	1,104	55	10		(55)	1,104	20
21	1 ROOFTOP A/C UNIT			1987	9,372		10			9,372	21
22	TELEPHONE SYSTEM			1987	2,794		20	140	140	1,890	22
23	STORAGE SHED			1988	11,422	363	20	571	208	7,138	23
24	LANDSCAPING			1988	1,998		10			1,998	24
25	INTERIOR DECORATING			1990	11,575	367	15	772	405	8,106	25
26	SMOKE DETECTORS			1990	1,764		15	118	118	1,239	26
27	CUBICLE TRACK			1990	3,804	121	20	190	69	1,995	27
28	DRAIN LINES ON DOWNSPOUTS			1990	928	62	15	62		651	28
29	CONCRETE PAD			1991	2,088	139	20	104	(35)	988	29
30	ROOFTOP A/C UNIT			1991	18,780	596	10	1,878	1,282	17,841	30
31	NEW ROOF			1991	60,596		20	3,030	3,030	28,785	31
32	SHOWER ROOM RENNOVATIONS			1992	5,465		15	364	364	3,094	32
33	ADDITION TO PHONE SYSTEM			1992	538		20	27	27	229	33
34	REMODEL PATIENT ROOM			1993	3,666	94	15	244	150	1,830	34
35	HOT WATER HEATER			1994	2,870	256	15	191	(65)	1,242	35
36	TOTAL (lines 4 thru 35)				$ 847,007	$ 2,053		$ 19,664	$ 17,611	$ 668,382	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0028472 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PARKING LOT REDONE			1995	21,259	1,417	15	1,417		7,794	9
10	PARKING LOT BUMPERS			1996	654	44	15	44		198	10
11	INSTALL CEILING FANS			1996	1,149	115	5	230	115	1,035	11
12	REPAIR SEWER LINE & REPLACE KITCHEN SINK DRAINS			1997	3,112	239	15	207	(32)	725	12
13	TILE DINNING ROOM			1998	628	110	15	42	(68)	105	13
14	SEAL & STRIPE PARKING LOT			1999	1,764	252	7	252		378	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 28,566	$ 2,177		$ 2,192	$ 15	$ 10,235	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0028472 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 84,240	$ 1,826	$ 8,322	$ 6,496	various	$ 45,041	37
38	Current Year Purchases	22,694	19,827	1,570	(18,257)	various	1,570	38
39	Fully Depreciated Assets	110,419				various	110,419	39
40								40
41	TOTALS	$ 217,353	$ 21,653	$ 9,892	$ (11,761)		$ 157,030	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 1,092,926	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 25,883	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 31,748	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 5,865	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 835,647	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 218 Description: STORAGE (114) EQUIPMENT (104)
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0028472 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

WE ONLY HIRE TRAINED AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39/3	hrs	$	67	$ 4,265	$	67	$ 4,265	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		7	471		7	471	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3;39/2	hrs		149	9,417	252	149	9,669	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/2	# of prescrpts				4,608		4,608	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	medical supplies, oxygen, tubefeeding Other (specify): labs	39/2 39/3				286	16,963		17,249	13
14	TOTAL			$	223	$ 14,439	$ 21,823	223	$ 36,262	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0028472 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 36,088	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	351,866		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	354,226		5
6	Prepaid Insurance	2,818		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): TAX DEPOSITS	8,200		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 753,198	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	115,713		15
16	Equipment, at Historical Cost	222,202		16
17	Accumulated Depreciation (book methods)	(278,537)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTRUCTION IN PROGRE	2,998		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 62,376	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 815,574	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 29,926	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	32,033		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,515		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	401 K LIABILITY	7,104		36
37	SALES TAX PAYABLE	86		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 87,664	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 87,664	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 727,910	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 815,574	$	48

***(See instructions.)**

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0028472 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 727,200	1
2	Restatements (describe):		2
3	1999 TAXES	(7,849)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 719,351	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	8,559	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 8,559	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 727,910	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0028472 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,992,697	1
2	Discounts and Allowances for all Levels	23,622	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,016,319	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	23,975	6
7	Oxygen	126,365	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 150,340	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	22,580	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 22,580	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,189,239	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	472,501	31
32	Health Care	909,810	32
33	General Administration	438,438	33
	B. Capital Expense		
34	Ownership	278,101	34
	C. Ancillary Expense		
35	Special Cost Centers	36,262	35
36	Provider Participation Fee	45,568	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,180,680	40
41	**Income before Income Taxes (line 30 minus line 40)****	8,559	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 8,559	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.** IL REPL & INCOME DEDUCTED ON FED

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0028472 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 44,282	$ 21.29	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,153	6,895	128,775	18.68	3
4	Licensed Practical Nurses	11,875	13,098	186,689	14.25	4
5	Nurse Aides & Orderlies	45,739	49,566	420,473	8.48	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,251	3,708	34,300	9.25	8
9	Activity Director	2,978	3,293	36,706	11.15	9
10	Activity Assistants					10
11	Social Service Workers	1,360	1,585	19,470	12.28	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,836	2,104	28,628	13.61	14
15	Cook Helpers/Assistants	10,422	11,344	95,781	8.44	15
16	Dishwashers					16
17	Maintenance Workers	1,809	1,959	19,316	9.86	17
18	Housekeepers	7,003	7,725	64,153	8.30	18
19	Laundry	4,322	4,890	45,616	9.33	19
20	Administrator	2,046	2,080	75,065	36.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,609	1,946	21,680	11.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	102,403	112,273	$ 1,220,934 *	$ 10.87	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	134	$ 6,254	1/3	35
36	Medical Director				36
37	Medical Records Consultant		350	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	600	10/3	39
40	Physical Therapy Consultant	123	6,662	10A/3	40
41	Occupational Therapy Consultant	2	94	10A/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	45	10A/3	43
44	Activity Consultant	42	2,160	11/3	44
45	Social Service Consultant	42	2,160	12/3	45
46	Other(specify)				46
47	PURCHASING CONSULTANT		1,175	19/3	47
48	BILLING CONSULTANT		7,010	19/3	48
49	TOTAL (lines 35 - 48)	392	$ 26,510		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0028472 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KEN ROWALD	ADMINISTRATOR	0	$ 75,065
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 75,065

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
M.E.S.	PURCHASING CONSULTA	$ 1,175
NCS HEALTHCARE	BILLING SERVICE	7,010
ADP	PAYROLL	453
MIKRON	COMPUTER	1,031
JACK LINK	ACCOUNTANT	485
JAMESTOWN MGMT	MANAGEMENT	120,493
BENEFIT PLANNING CONS.	401K SERVICES	1,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 131,647

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,446
Unemployment Compensation Insurance	7,980
FICA Taxes	93,401
Employee Health Insurance	12,651
Employee Meals	9,340
Illinois Municipal Retirement Fund (IMRF)*	
401K CONTRIBUTIONS	5,375
BONUSES	80
PARTIES, MERIT PAY, X-MAS, ETC.	19,245
TOTAL (agree to Schedule V, line 22, col.8)	$ 188,518

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	40
Health Care Worker Background Check	108
(Indicate # of checks performed 9)	
SUBSCRIPTIONS(76) INHAA DUES(75)	151
CLIA LAB(150)CORP FEE(50)	200
NAGNA(1877) NOTARY FEE(10)	1,887
FIRE MARSHALL INSPECTION	20
HELP WANTED & OTHER ADV(ELIM)	1,906
Less: Public Relations Expense	( )
Non-allowable advertising	(1,906)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,606

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,127
Seminar Expense	2,005
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,132

**See instructions.

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0028472 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINTING	1194	$ 2,442	3	$ 407	$	$	$	$	$	$	$	$
2	PAINTING	1995	5,847	3	1,949	974							
3	PAINTING	1996	2,585	3	862	862	430						
4	PAINTING	1997	3,549	3	592	1,183	1,183	591					
5	PAINTING	1998	1,962	3		327	654	654	327				
6	PAINTING	1999	6,837	3			1,140	2,279	2,279	1,139			
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 23,222		$ 3,810	$ 3,346	$ 3,407	$ 3,524	$ 2,606	$ 1,139	$	$	$

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME **#** 0028472 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **8 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **45,568**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **9,340** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

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THREE SPRINGS LODGE NURSING HOME INC.

RECLASSIFICATIONS FOR PG 3&4 COLUMN #5 DPA COST REPORT

12/31/2000

COL 5 LINE #	ACCOUNT TITLE DESCRIPTION	DEBIT	CREDIT
22	EMPLOYEE BENEFITS	9340	
2	FOOD PURCHASES		9340
	RECL COST OF EMPLOYEE MEALS		
2	FOOD PURCHASES	5309	
10	NURSING SUPPLIES		5309
	RECL FOOD SUPPLEMENTS		
22	EMPLOYEE BENEFITS	40446	
26	INSURANCE		40446
	RECL WORKER'S COMP INSURANCE		